

1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
13658
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13627

1. PLACE OF DEATH o. COUNTY <i>CARDINE</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>CAROLINE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillsboro</i>		c. LENGTH OF STAY IN 1b <i>6 wks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 138</i>		e. STREET ADDRESS <i>Box 138</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ohie Bentley</i>		4. DATE OF DEATH Month <i>12</i> Day <i>30</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-5-88</i>
9. AGE (In years lost birthday) <i>72</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm laborer</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Bentley</i>		14. MOTHER'S MAIDEN NAME <i>Georgina Gardner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>218-07-4461</i>	
17. INFORMANT <i>Alice Eggenon, Wilmington, Del.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis of the art. of the brain</i> DUE TO (c) <i>Hypertensive cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i> <i>more than 10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8:00 PM</i> to <i>Dec 30</i> 19 <i>60</i> that (I) (we) last saw the deceased alive and <i>3:30 PM</i> 19 <i>60</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Kurt Lederer</i>		22b. DATE SIGNED <i>1/5/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>KURT LEDERER</i>		22d. ADDRESS <i>QUEEN ANNE MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11/7/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Sandtown Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Hillsboro Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>James Goshier</i>		24. ADDRESS <i>Easton, Md.</i>	
25a. REC'D BY REGISTRAR DATE <i>JAN 10 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>	

EXHIBIT A OF DEATH

10058

10058

CERTIFICATE OF DEATH

Reg. Dist. No.

13655

13628

1. PLACE OF DEATH a. COUNTY Caroline Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Del. b. COUNTY Subsex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hickman, Del.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willeoughby Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Elizabeth Middle Brown Last Brown		4. DATE OF DEATH Month 12 Day 22 Year 1960	
5. SEX Fem.	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24 1877
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3	11. IF UNDER 24 HRS. Hours 3 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired H. W.		10b. KIND OF BUSINESS OR INDUSTRY Caroline Co Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wesley Covey		14. MOTHER'S MAIDEN NAME Mary Phillips	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. W. Covey Brown, Denton, Md., R.D. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) 10 yrs?		INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 8, 1960 to Dec 22, 1960 that I last saw the deceased alive on Dec 22, 1960 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Lannon M.D.		ADDRESS (Street, city or town, state) Federalburg Md. 12-23-60	
PHYSICIAN'S NAME (Type) W. E. Lannon M.D.		Federalburg Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/26/60	22c. NAME OF CEMETERY OR CREMATORY Hollywood	22d. LOCATION (City, town, or county) (State) Harrington, Del.
23. FUNERAL DIRECTOR'S SIGNATURE William Berry Jr., Milford, Del.		24a. REC'D BY REGISTRAR DEC 30 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thrush			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1885

State of New York, County of New York, City of New York.

I, the undersigned, being a duly qualified physician, do hereby certify that

the within and foregoing is a true and correct copy of the

original as the same appears from the records of the

Office of the Registrar of Births and Deaths.

Witness my hand and seal this 1st day of January, 1885.

Attest: J. D. S. Mayor, City of New York.

[Faint, illegible text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13659

CERTIFICATE OF DEATH

Reg. Dist. No.

13629

1. PLACE OF DEATH o. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Everett</u> Middle <u>Forster</u> Last <u>Gale</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 30, 1866</u>		9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raisin Gale</u>				14. MOTHER'S MAIDEN NAME <u>Indiana Forster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Stewart Gale, Hillsboro, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Obstructive jaundice</u> (c) <u>Neoplasma of papilla of Vater</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 weeks</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>43</u> , to <u>Dec 28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>60</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Kurt Lederer</u> M.D. <u>Dec 30, 1960</u> PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u> <u>QUEEN ANNE MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 30, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wagoner</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 3 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

1883

CERTIFICATE OF DEATH

1880

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "Name", "Date", "Place", and "Cause of Death".

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13656
CERTIFICATE OF DEATH

13631

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 Bloomingdale Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nettie Middle Leah Last Hignutt		4. DATE OF DEATH Month December Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1899
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 24 Days 24 Hours 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Caroline County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Tribbett		14. MOTHER'S MAIDEN NAME Irena Covey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-0331	
17. INFORMANT J. Fletcher Hignutt, Federalsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchial Asthma DUE TO (c) 20 yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1958 to Dec. 24, 1960 , that (I) (we) last saw the deceased alive on 12-24, 1960 and that death occurred at 7 PM , from the causes and on the date stated above.			
22a. SIGNATURE H. B. Trapnell, MD		22b. DATE SIGNED 12-26-60	
22c. PHYSICIAN'S NAME (Type) H. B. Trapnell, MD		22d. ADDRESS Federalsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 28, 1960	
23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		23d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR DATE JAN 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13658

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS

County of ...

City of ...

Town of ...

Ward of ...

DECEASED

IN DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

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PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13632

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Marydel		c. LENGTH OF STAY IN 1b 60 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Temple Middle Kenton Last Kenton		4. DATE OF DEATH Month 12 Day 28 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-3-1895
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eli Kenton		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Pauline Janson Marydel, Maryland		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound through head probably afew min. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased shot himself	
20c. TIME OF INJURY Month, Day, Year 7:45 Hour o. m. Dec 28 19 60 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Marydel Caroline Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. Paul Knotts		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. Paul Knotts		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec 29, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-60	
22c. NAME OF CEMETERY OR CREMATORY Busic		22d. LOCATION (City, town, or county) (State) Near Barclay, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boula's Greensboro, Md.		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR DEC 3 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

13661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. EDUCATION [Illegible]	
9. PRESENT ADDRESS [Illegible]		10. DATE OF DEATH [Illegible]	
11. CAUSE OF DEATH [Illegible]		12. MANNER OF DEATH [Illegible]	
13. SIGNATURE OF EXAMINER [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. DATE OF EXAMINATION [Illegible]		16. TIME OF EXAMINATION [Illegible]	
17. SIGNATURE OF REGISTRAR [Illegible]		18. SIGNATURE OF CLERK [Illegible]	
19. DATE OF REGISTRATION [Illegible]		20. TIME OF REGISTRATION [Illegible]	
21. SIGNATURE OF DECEASED [Illegible]		22. SIGNATURE OF NEXT OF KIN [Illegible]	
23. SIGNATURE OF SURGEON [Illegible]		24. SIGNATURE OF PHYSICIAN [Illegible]	
25. SIGNATURE OF DENTIST [Illegible]		26. SIGNATURE OF NURSE [Illegible]	
27. SIGNATURE OF MIDWIFE [Illegible]		28. SIGNATURE OF OTHER [Illegible]	
29. SIGNATURE OF OTHER [Illegible]		30. SIGNATURE OF OTHER [Illegible]	
31. SIGNATURE OF OTHER [Illegible]		32. SIGNATURE OF OTHER [Illegible]	
33. SIGNATURE OF OTHER [Illegible]		34. SIGNATURE OF OTHER [Illegible]	
35. SIGNATURE OF OTHER [Illegible]		36. SIGNATURE OF OTHER [Illegible]	
37. SIGNATURE OF OTHER [Illegible]		38. SIGNATURE OF OTHER [Illegible]	
39. SIGNATURE OF OTHER [Illegible]		40. SIGNATURE OF OTHER [Illegible]	
41. SIGNATURE OF OTHER [Illegible]		42. SIGNATURE OF OTHER [Illegible]	
43. SIGNATURE OF OTHER [Illegible]		44. SIGNATURE OF OTHER [Illegible]	
45. SIGNATURE OF OTHER [Illegible]		46. SIGNATURE OF OTHER [Illegible]	
47. SIGNATURE OF OTHER [Illegible]		48. SIGNATURE OF OTHER [Illegible]	
49. SIGNATURE OF OTHER [Illegible]		50. SIGNATURE OF OTHER [Illegible]	
51. SIGNATURE OF OTHER [Illegible]		52. SIGNATURE OF OTHER [Illegible]	
53. SIGNATURE OF OTHER [Illegible]		54. SIGNATURE OF OTHER [Illegible]	
55. SIGNATURE OF OTHER [Illegible]		56. SIGNATURE OF OTHER [Illegible]	
57. SIGNATURE OF OTHER [Illegible]		58. SIGNATURE OF OTHER [Illegible]	
59. SIGNATURE OF OTHER [Illegible]		60. SIGNATURE OF OTHER [Illegible]	
61. SIGNATURE OF OTHER [Illegible]		62. SIGNATURE OF OTHER [Illegible]	
63. SIGNATURE OF OTHER [Illegible]		64. SIGNATURE OF OTHER [Illegible]	
65. SIGNATURE OF OTHER [Illegible]		66. SIGNATURE OF OTHER [Illegible]	
67. SIGNATURE OF OTHER [Illegible]		68. SIGNATURE OF OTHER [Illegible]	
69. SIGNATURE OF OTHER [Illegible]		70. SIGNATURE OF OTHER [Illegible]	
71. SIGNATURE OF OTHER [Illegible]		72. SIGNATURE OF OTHER [Illegible]	
73. SIGNATURE OF OTHER [Illegible]		74. SIGNATURE OF OTHER [Illegible]	
75. SIGNATURE OF OTHER [Illegible]		76. SIGNATURE OF OTHER [Illegible]	
77. SIGNATURE OF OTHER [Illegible]		78. SIGNATURE OF OTHER [Illegible]	
79. SIGNATURE OF OTHER [Illegible]		80. SIGNATURE OF OTHER [Illegible]	
81. SIGNATURE OF OTHER [Illegible]		82. SIGNATURE OF OTHER [Illegible]	
83. SIGNATURE OF OTHER [Illegible]		84. SIGNATURE OF OTHER [Illegible]	
85. SIGNATURE OF OTHER [Illegible]		86. SIGNATURE OF OTHER [Illegible]	
87. SIGNATURE OF OTHER [Illegible]		88. SIGNATURE OF OTHER [Illegible]	
89. SIGNATURE OF OTHER [Illegible]		90. SIGNATURE OF OTHER [Illegible]	
91. SIGNATURE OF OTHER [Illegible]		92. SIGNATURE OF OTHER [Illegible]	
93. SIGNATURE OF OTHER [Illegible]		94. SIGNATURE OF OTHER [Illegible]	
95. SIGNATURE OF OTHER [Illegible]		96. SIGNATURE OF OTHER [Illegible]	
97. SIGNATURE OF OTHER [Illegible]		98. SIGNATURE OF OTHER [Illegible]	
99. SIGNATURE OF OTHER [Illegible]		100. SIGNATURE OF OTHER [Illegible]	

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Page 4
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13657
13633
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Iva Middle Murphy Last Murphy		4. DATE OF DEATH Month 12 Day 25 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-12-7764	
17. INFORMANT Helen Edwards Address Greensboro, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Dis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage with Residual Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1960, to Dec. 25, 1960, that (I) (we) last saw the deceased alive on Dec. 25, 1960, and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonessifer		22b. DATE 12/27/60	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonessifer, M.D.		22d. ADDRESS Greensboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-60	
23c. NAME OF CEMETERY OR CREMATORY Greensboro		23d. LOCATION (City, town, or county) Greensboro, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais		25. REC'D BY REGISTRAR DATE DEC 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

CERTIFICATE OF DEATH

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13662
13634
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENSBORO - RURAL</u>				c. LENGTH OF STAY IN 1b <u>36 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>IRVING'S CHAPEL ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>MELVIN</u> Last <u>NICHOLS</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 15, 1906</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAY LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>CAROLINE COUNTY, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>LOUIS NICHOLS</u>			
14. MOTHER'S MAIDEN NAME <u>SARAH E. JAMES</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>GEORGE E. NICHOLS, GREENSBORO, MARYLAND, RFD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cardiovascular Renal Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 17, 1960</u> to <u>Dec. 28, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28, 1960</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles H. Stonesifer</u>				22b. DATE SIGNED <u>DEC. 28, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>				22d. ADDRESS <u>Greensboro, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 31, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CROAKER'S CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>NEAR GREENSBORO, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. FRAMPTON AND SON, FEDERALSBURG, MARYLAND</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

BP

1964

CERTIFICATE OF DEATH

1964

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of registrar: [illegible]
9. Signature of medical officer: [illegible]
10. Signature of informant: [illegible]

CERTIFICATE OF DEATH

13635

1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Greensboro		c. LENGTH OF STAY IN 1b		3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Ridgely					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Cherry Nursing Home		d. STREET ADDRESS		/ None		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
Hattie						Pinder		12		31		19		60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8-2-1881		79		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Housewife		None		Maryland		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
William Slaughter		Elizabeth Biddle													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		706 Gay Street									
No		None		Bertha Collison		Denton, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Metastatic Carcinoma of retroperitoneal gland and liver													
171X		DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Carcinoma of Cervix											
DUE TO		(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
Hour o. m. p. m.		While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>													
21. I certify that (I) (this hospital) attended the deceased from Oct. 12, 1960, to Dec. 31, 1960, that (I) (we) last saw the deceased alive on Dec. 31, 1960, and that death occurred at 7:15 P.M. from the causes and on the date stated above.															
22a. SIGNATURE		22b. DATE SIGNED													
Charles H. Stonifer															
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS													
Charles H. Stonifer, M.D.		Greensboro, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)							
Burial		1-3-61		Greensboro		Greensboro, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
J.E. Boulaie		Greensboro, Md.		DATE JAN 6 '61		Arthur S. Kraus									

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13653

CERTIFICATE OF DEATH

Reg. Dist. No.

13636

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MILDRED ROENA ROE				4. DATE OF DEATH Month Day Year DEC 16 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR 12, 1906	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME FRANK THOMAS				14. MOTHER'S MAIDEN NAME MOLLY WRIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Calvin Roe, Denton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 15 mo.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 16, 1960 , to Dec 16, 1960 , that I last saw the deceased alive on Dec 16, 1960 , and that death occurred at 7:30 p.m. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE E Paul Knotts M.D. PHYSICIAN'S NAME (Type) E Paul Knotts MD Denton Md							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec 19, 1960		Denton		Denton Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
John Edgar Moore & Son Denton				DEC 27 1960		Arthur E. Knott	

CERTIFICATE OF DEATH

1963

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF BIRTH [Faint handwritten date]		PLACE OF BIRTH [Faint handwritten place]		DATE OF DEATH [Faint handwritten date]	
TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]		CAUSE OF DEATH [Faint handwritten cause]	
MANNER OF DEATH [Faint handwritten manner]		MEDICAL HISTORY [Faint handwritten medical history]		PREVIOUS ILLNESS [Faint handwritten previous illness]	
OCCUPATION [Faint handwritten occupation]		EDUCATION [Faint handwritten education]		SOCIAL HISTORY [Faint handwritten social history]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
DATE OF SIGNATURE [Faint handwritten date]		DATE OF SIGNATURE [Faint handwritten date]		DATE OF SIGNATURE [Faint handwritten date]	

THIS CERTIFICATE IS VALID ONLY IF FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND.

1963
 BALTIMORE, MARYLAND
 OFFICE OF THE REGISTRAR OF DEATHS

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13637

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MILTON Middle ALFRED Last SCHLEGEL				4. DATE OF DEATH Month DEC. Day 15 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 2, 1900	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired) Sanitor		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL BLDG		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS SCHLEGEL				14. MOTHER'S MAIDEN NAME COHRE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Name M. Alfred Schlegel Address Denton			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis 420 DUE TO (b) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs -	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dawson O. George M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) DAWSON O. GEORGE				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 12.17.60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 18, 1960		22c. NAME OF CEMETERY OR CREMATORY Denton		22d. LOCATION (City, town, or country) (State) Denton, Md.	
23. FUNERAL DIRECTOR Winget H. H. H. H.				ADDRESS Denton		24a. REC'D BY REGISTRAR DEC 21 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. H. H.			

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

CERTIFICATE OF DEATH

13638

Reg. Dist. No.

13664

1. PLACE OF DEATH o. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON	
c. LENGTH OF STAY IN 1b life		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LINWOOD MANSHIP WISHER		4. DATE OF DEATH DEC 2, 1960	
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 13, 1895
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Wisner		14. MOTHER'S MAIDEN NAME Laura Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. WV 1	
17. INFORMANT Wesley Lindwood Wisner		Address Denton, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation 526X DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic bronchitis, emphysema and bronchiectasis DUE TO (c) Chronic bronchitis, emphysema and bronchiectasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days 4 years 12 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1930 , 19____, to Dec 2, 1960 , that I last saw the deceased alive on Dec 2 , 19____, and that death occurred at 5 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 406 Market St DATE SIGNED ACTUAL SIGNATURE E. Paul Knotts M.D. PHYSICIAN'S NAME (Type) E. Paul Knotts M.D. Denton, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 6, 1960	
22c. NAME OF CEMETERY OR CREMATORY Spring Grove		22d. LOCATION (City, town, or county) (State) Denton Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley Lindwood Wisner		ADDRESS Denton, Md	
24a. REC'D BY REGISTRAR DEC 12 '60		24b. REGISTRAR'S SIGNATURE Wesley Lindwood Wisner	

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH NEW YORK	
6. OCCUPATION LABORER		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE NEW YORK		10. NAME OF SPOUSE MARY J. BROWN	
11. DATE OF DEATH 1955		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH HOME		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF PHYSICIAN [Signature]		19. SIGNATURE OF CLERK [Signature]		20. SIGNATURE OF REGISTRAR [Signature]	
21. PLACE OF INTERMENT CATHOLIC CEMETERY		22. NAME OF CEMETERY ST. MARY'S		23. ADDRESS OF CEMETERY 123 MAIN ST.		24. CITY OF CEMETERY BOSTON		25. STATE OF CEMETERY MASSACHUSETTS	
26. NAME OF FUNERAL HOME JOHN J. BROWN		27. ADDRESS OF FUNERAL HOME 123 MAIN ST.		28. CITY OF FUNERAL HOME BOSTON		29. STATE OF FUNERAL HOME MASSACHUSETTS		30. NAME OF FUNERAL HOME JOHN J. BROWN	
31. NAME OF FUNERAL HOME JOHN J. BROWN		32. ADDRESS OF FUNERAL HOME 123 MAIN ST.		33. CITY OF FUNERAL HOME BOSTON		34. STATE OF FUNERAL HOME MASSACHUSETTS		35. NAME OF FUNERAL HOME JOHN J. BROWN	
36. NAME OF FUNERAL HOME JOHN J. BROWN		37. ADDRESS OF FUNERAL HOME 123 MAIN ST.		38. CITY OF FUNERAL HOME BOSTON		39. STATE OF FUNERAL HOME MASSACHUSETTS		40. NAME OF FUNERAL HOME JOHN J. BROWN	
41. NAME OF FUNERAL HOME JOHN J. BROWN		42. ADDRESS OF FUNERAL HOME 123 MAIN ST.		43. CITY OF FUNERAL HOME BOSTON		44. STATE OF FUNERAL HOME MASSACHUSETTS		45. NAME OF FUNERAL HOME JOHN J. BROWN	
46. NAME OF FUNERAL HOME JOHN J. BROWN		47. ADDRESS OF FUNERAL HOME 123 MAIN ST.		48. CITY OF FUNERAL HOME BOSTON		49. STATE OF FUNERAL HOME MASSACHUSETTS		50. NAME OF FUNERAL HOME JOHN J. BROWN	
51. NAME OF FUNERAL HOME JOHN J. BROWN		52. ADDRESS OF FUNERAL HOME 123 MAIN ST.		53. CITY OF FUNERAL HOME BOSTON		54. STATE OF FUNERAL HOME MASSACHUSETTS		55. NAME OF FUNERAL HOME JOHN J. BROWN	
56. NAME OF FUNERAL HOME JOHN J. BROWN		57. ADDRESS OF FUNERAL HOME 123 MAIN ST.		58. CITY OF FUNERAL HOME BOSTON		59. STATE OF FUNERAL HOME MASSACHUSETTS		60. NAME OF FUNERAL HOME JOHN J. BROWN	
61. NAME OF FUNERAL HOME JOHN J. BROWN		62. ADDRESS OF FUNERAL HOME 123 MAIN ST.		63. CITY OF FUNERAL HOME BOSTON		64. STATE OF FUNERAL HOME MASSACHUSETTS		65. NAME OF FUNERAL HOME JOHN J. BROWN	
66. NAME OF FUNERAL HOME JOHN J. BROWN		67. ADDRESS OF FUNERAL HOME 123 MAIN ST.		68. CITY OF FUNERAL HOME BOSTON		69. STATE OF FUNERAL HOME MASSACHUSETTS		70. NAME OF FUNERAL HOME JOHN J. BROWN	
71. NAME OF FUNERAL HOME JOHN J. BROWN		72. ADDRESS OF FUNERAL HOME 123 MAIN ST.		73. CITY OF FUNERAL HOME BOSTON		74. STATE OF FUNERAL HOME MASSACHUSETTS		75. NAME OF FUNERAL HOME JOHN J. BROWN	
76. NAME OF FUNERAL HOME JOHN J. BROWN		77. ADDRESS OF FUNERAL HOME 123 MAIN ST.		78. CITY OF FUNERAL HOME BOSTON		79. STATE OF FUNERAL HOME MASSACHUSETTS		80. NAME OF FUNERAL HOME JOHN J. BROWN	
81. NAME OF FUNERAL HOME JOHN J. BROWN		82. ADDRESS OF FUNERAL HOME 123 MAIN ST.		83. CITY OF FUNERAL HOME BOSTON		84. STATE OF FUNERAL HOME MASSACHUSETTS		85. NAME OF FUNERAL HOME JOHN J. BROWN	
86. NAME OF FUNERAL HOME JOHN J. BROWN		87. ADDRESS OF FUNERAL HOME 123 MAIN ST.		88. CITY OF FUNERAL HOME BOSTON		89. STATE OF FUNERAL HOME MASSACHUSETTS		90. NAME OF FUNERAL HOME JOHN J. BROWN	
91. NAME OF FUNERAL HOME JOHN J. BROWN		92. ADDRESS OF FUNERAL HOME 123 MAIN ST.		93. CITY OF FUNERAL HOME BOSTON		94. STATE OF FUNERAL HOME MASSACHUSETTS		95. NAME OF FUNERAL HOME JOHN J. BROWN	
96. NAME OF FUNERAL HOME JOHN J. BROWN		97. ADDRESS OF FUNERAL HOME 123 MAIN ST.		98. CITY OF FUNERAL HOME BOSTON		99. STATE OF FUNERAL HOME MASSACHUSETTS		100. NAME OF FUNERAL HOME JOHN J. BROWN	